STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 00 B. WING	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH CARE CENTER LLC	7465 MADISON AVE INDIANAPOLIS, IN 46227

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F0000	This visit was for the Investigation of Complaint IN00103620. Complaint IN00103620- Substantiated. Federal/state deficiencies related to the allegation are cited at F309, F329, F425 and F514 Survey dates: March 6, 7, 8, 2012 Facility number: 012225 Provider number: 155780 AIM number: 200983560 Survey team: Carol Miller, RN- TC Census bed type: SNF: 19 SNF/NF: 56 Total: 75 Census payor type: Medicare: 23 Medicaid: 34 Other: 18 Total: 75 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	**This plan of correction is to serve as Madison Health Care Center's credible allegation of compliance.** **Submission of this plan of correction does not constitute an admission by Madison Health Care Center or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.** **Madison Health Care Center is in full compliance as of 04/01/2012. We respectfully request paper review.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on March 13, 2012 by Bev Faulkner, RN			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based interviews and record review, the facility failed to ensure adequate and thorough assessments were completed for 1 resident who was sent to the local hospital emergency room with complaints of abdominal pain, vomiting and hypoactive bowel sounds. (Resident B) This deficiency affected 1 of 3 residents reviewed for the care and services in a sample of 3. Findings include: The closed clinical record of Resident B was reviewed on 3/7/12 at 9:30 a.m., and indicated Resident B's diagnoses included, but were not limited to, lateral malleolus fracture of left ankle and renal artery stenosis status post right artery stenting and coronary artery disease status post myocardial infarction, post operative anemia and dementia. The resident was admitted to the facility on 11/6/11 from the local hospital after a fractured ankle and post surgical open	F0309	**F309 483.25 PROVIDE CARE SERVICES FOR HIGHEST WELL BEING** It is the practice of Madison Health Care Center to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. I. Resident B no longer resides in the facility. II. The facility realizes other residents have the potential to be affected. This has been addressed by the systems described below. III. Licensed nurses have been re-educated regarding bowel assessments. In addition, the facility has implemented a new bowel monitoring record that includes observation of the resident's bowel movement including consistency, amount, and size. Licensed nurses and	04/01/2012

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	reduction. The resident was transferred back to the hospital on 11/22/11. The Nurse's Notes indicated the following: On 11/11/11 at 1:00 p.m., the resident was incontinent of bowel, there was no further documentation describing the consistency or amount. On 11/13/11 at 2:00 p.m., the nurse documented "...Res (resident) (symbol for no) BM x (times) 3 days or more, c/o (complaints of) constipation. Wrote standing order M.O.M (Milk of Magnesia for constipation) 30 milliliters (ML) PRN (as needed) daily. Asked to advise for daily stool softener. MD (Physician) faxed,...Provided 30 ML of M.O.M. Will monitor for outcome...." There was a Physician's Order written on 11/13/11 for MOM 30 ml every day as needed for constipation and there was no mention of an order for a stool softener . There was also a Physician's Order written on 11/15/11 for Niferex (an iron supplement) give 150 milligrams two times a day for post-op anemia. On 3/8/12 at 8:45 a.m., LPN #1 was interviewed in regard to the results of the MOM administered on 11/13/11. LPN #1		nursing assistants have been educated on this new policy and procedure. IV. The Director of Nursing or her designee is conducting quality improvement audits of the bowel monitoring record including documentation of bowel movements. A random sample of 5 residents is being checked weekly for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary.	

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	indicated after she gave Resident B the MOM he had a formed BM on 11/14/11 and "...Every day after that..." The Nurse's Notes, dated 11/17/11 through 11/19/11 at 4:00 a.m., indicated the resident was incontinent of bowel and there was no documentation to indicate the amount and consistency of the BM. On 11/19/11 at 1:00 p.m., the resident was continent of bowel. On 11/20/11 at 2:00 a.m., the resident was incontinent of bowel and there was no documentation in regard to the amount and consistency. The Nurse's Note further indicated the resident had no complaints of pain or discomfort. The Nurse's Notes further indicated the following: On 11/21/11 at 9:00 p.m., RN #3 documented the resident had nausea and vomiting 5 times after the evening meal. The vital signs were taken and the resident's temperature was 98.6, pulse was 72 respirations 16 and blood pressure 148/72. RN #3 had notified the Physician and ordered stat (immediate) a KUB (radiology test of the kidney, urerter and bladder), a CBC (laboratory test complete blood count), BMP (basic metabolic panel), UA and C/S laboratory			

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	tests(urinalysis and culture and sensitivity). The Physician also ordered phenergan 25 milligrams every 8 hours as needed for nausea and vomiting. RN #3 gave the resident the phenergan. The CBC and BMP results were back and the Physician was notified and indicated no new orders were given. The Nurse's Note indicated RN #3 will continue to monitor. The was no documentation RN #3 had assessed the resident's abdomen or listened to the bowel sounds. On 3/8/11 at 9:45 a.m., an interview with RN #3 in regard to Resident B's condition on 11/21/11, RN #3 indicated 11/21/11 was the first time she had taken care of Resident B. RN #3 indicated the resident had gone to supper and ate well and was taken back to his room when he had started to vomit. RN #3 had taken the resident's vital signs and blood sugar and the results were "...ok" and she listened to his bowel sounds and they were hypoactive. RN #3 notified the resident's physician and he had provided new orders for the tests. The Nurse's Notes dated 11/22/11 at 3:00 a.m., indicated the resident was resting in bed and the UA sample was obtained, "...Res (resident) tolerated well..." The resident had no complaints of pain. The KUB results were back and the Physician			

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	was notified and no new orders were received. "...Will monitor." There were no vital signs or abdominal assessment documented as completed. The Abdomen KUB radiology test results, dated 11/21/11, indicated there was no evidence of a acute bowel obstruction. The Nurse's Notes, dated 11/22/11 at 1:00 p.m., indicated the resident ate 100 percent of lunch. The resident was medicated with Tramodol for back pain. The resident's accucheck for blood glucose was high at 415 and was given insulin coverage and was rechecked and the result was 175. "...Staff witnessed res (resident) putting finger down his throat. States wants to throw up so he can go to bed. Cont (continent) of B+B (bowel and bladder) this shift. No emesis of diarrhea...." LPN #1 obtained the vital signs: temperature 98.1, pulse 72, respirations 16 blood pressure 132/78 and oxygen level on room air was 97%. On 3/8/11 at 8:45 a.m., an interview with LPN #1 in regard to Resident B's condition on 11/22/11 and LPN #1 indicated the resident had eaten all of lunch and was taking fluids well. LPN # 1 further indicated the resident was combative, but after she spoke with the resident he calmed down. LPN #1			

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	indicated the resident was sitting at the nurses station because he felt sick and he tried to stick his fingers down his throat once in the dining room and once after that and LPN #1 indicated the resident had not vomited. When the family came in to visit the resident, the staff had laid the resident down in bed. LPN #1 indicated the resident started to complain of lower abdominal pain and upon listening his bowel sounds were hypoactive. LPN #1 indicated the family was concerned and with the abdominal pain the resident was experiencing. LPN #1 notified the Nurse Practitioner. The Nurse's Note, dated 11/22/11 at 2:00 p.m., indicated the resident's Physician Nurse Practitioner found blood in the resident's stool and new complaints of right sided abdominal pain and an order was received to send the resident to the local Emergency Room. On 11/22/11, the Nurse Practitioner documented the resident had pain with palpitation to the right and left upper quadrants, the bowel sounds were hypoactive and the abdomen was firm and guarding. The Nurse Practitioner indicated the stool was scant and the color melena (black, tarry). The Nurse's Note, dated 11/22/11 at 3:10			

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	p.m., the resident was having projectile vomiting and heart rate was 105. The resident left the facility by stretcher and was transported to the closest local hospital emergency room due to increased distress. On 11/22/11 at 16:42:00 (4:42 p.m.) at the hospital in the emergency room a Radiology test ABDOMEN ACUTE indicated, "...consistent with small bowel obstruction..." On 11/22/11 at 17:16:00 (5:16 p.m.) at the Hospital Emergency Room, a Computerized Tomography (CT) was performed and indicated "...Findings are most consistent with ischemic dead bowel." The CNA ADL (Activity Daily Living) form in regard to the documentation of Resident B's bowel movements were not available for review. On 3/7/11 at 11:45 a.m., an interview with the Director of Nursing Service (DNS) in regard to the CNA ADL form unavailable for review, the DNS indicated after the resident had been sent to the local hospital ER and passed away she looked though the resident's chart and was unable to locate the CNA ADL form. The DNS further indicated she had interviewed the CNAs who had cared for			

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	the resident and the CNAs indicated to the DNS the resident was having bowel movements (BM) and were documenting the BMs on the CNA ADL Form. On 3/8/12 at 9:30 a.m., during an interview with CNA #4 in regard to Resident B's condition, CNA #4 indicated the resident would stick his fingers down his throat at meals. CNA #4 indicated the resident did not stick his fingers down his throat every day. On 3/8/12 at 9:35 a.m., an interview with the DNS in regard to the resident's condition the DNS indicated she had spoken to CNA #5 who indicated the resident had a BM 1-2 days prior to 11/22/11. This federal tag is related to Complaint #IN00103620 3.1-37(a)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to monitor the coagulation time of the medication Coumadin for 1 of 2 residents reviewed who received anti-coagulation therapy in a sample of 3 (Resident B). Findings Include: The closed clinical record of Resident B was reviewed on 3/7/12 at 9:30 a.m., and indicated Resident B's diagnoses included, but were not limited to, lateral	F0329	**F329 483.25(l) UNNECESSARY DRUGS** It is the practice of Madison Health Care Center to ensure that each resident's drug regimen is free from unnecessary drugs. I. Resident B no longer resides in the facility. II. The records of residents who are receiving anticoagulant therapy have been audited to ensure no other PT/INR lab tests were incomplete. No concerns	04/01/2012

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	malleolus fracture of left ankle and renal artery stenosis status post right artery stenting and coronary artery disease-status post myocardial infarction. The resident was admitted to the facility on 11/6/11 from the local hospital due to a fracture of the ankle and surgical open reduction. The local hospital Physician's Order, dated 11/4/11 at 0916 (9:16 a.m.), indicated 2 milligrams vitamin k intravenously once now. Draw an INR stat at 1500 (3:00 p.m.) today. Also on 11/4/11 (time illegible) indicated an order to resume the Coumadin on 11/5/11 "...Restart normal daily schedule..." On 11/5/11 at 03:35 (3:00 a.m.), the Laboratory Grid Form indicated INR was 1.09 and the PT was 11.4. On 11/6/11 at 02:59 (2:59 a.m.), indicated the INR was 1.17 and the PT was 12.2. The admission Physician's Orders, dated 11/6/11, indicated an order for Warfarin (anticoagulant medication-generic for Coumadin) 5 milligrams (MG) every day except Monday and Thursday when the resident would receive 6 MG of Warfarin. The November 2011 Medication Administration Record was reviewed and indicated the resident had received		were identified. III. The facility has a policy regarding unnecessary drugs. Licensed nurses have been re-educated on this policy which reinforced the importance of following physician orders related to monitoring lab values with anticoagulant therapy. Lab orders are reviewed during morning clinical meeting and checked to ensure that the lab test has been requisitioned correctly. Nurses have been re-educated on the system for ordering lab tests. IV. The Director of Nursing or her designee is conducting quality improvement audits of residents receiving anticoagulant therapy to ensure the lab test was completed as ordered. This audit is being completed weekly for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary.	

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	Warfarin 5 mg except on Monday and Thursday when the the resident had received 6 mg. The Physician's Order, dated 11/8/11, and indicated to draw a Protime (PT) and an International Ratio (INR) laboratory test in the a.m. and then every Monday. There were no PT/INR laboratory test results on the chart for 11/9, 11/14 and 11/21/11. On 11/22/11, the resident was transferred to the local hospital Emergency Room and a PT/INR was drawn at 1550 (3:50 p.m.) and indicated the PT was high at 21.0 and normal was 9.5-11.9 and the INR was 1.99 (normal is 2.0-3.0). On 3/7/12 at 1:00 p.m., the Director of Nursing Service (DNS) was interviewed in regard to the PT/INR laboratory test ordered for 11/9, 11/14 and 11/21/11. The DNS indicated she could not answer why the PT/INR was not done and she had called the laboratory and they could not confirm the PT/INR were ever ordered. The DNS indicated it was the nurses responsibility for transcribing the Physician Orders. This federal tag is related to Complaint			

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	#IN00103620 3.1-48(a)(3)			

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F0425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on record review and interview, the facility failed to ensure the correct dosages of sliding scale insulin were administered for 1 resident. This deficiency affected 1 of 3 residents on a sliding scale in a sample of 3 (Resident C). Findings include: The record of Resident C was reviewed on 3/6/12 at 1:45 p.m., and indicated Resident C's diagnoses included, but were not limited to, diabetes. The Physician Order Sheet for March 2012, dated 12/7/11, indicated the resident was to have Accuchecks (fingerstick glucose monitoring) at 7:00 a.m. and 5:00 p.m. The order indicated administer Novolog 100 units/milliliters according to a sliding scale if the blood glucose was 200 to	F0425	**F425 483.60(a)(b) PHARMACEUTICAL SVC, ACCURATE PROCEDURES, RPH** It is the practice of Madison Health Care Center to provide routine and emergency drugs and biological to its residents; and to provide services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. I. Resident C is receiving insulin as ordered. II. Residents who receive sliding scale insulin have the potential to be affected. Two nurses that were identifed have been re-educated on blood	04/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155780	A. BUILDING 00 B. WING	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTH CARE CENTER LLC	7465 MADISON AVE INDIANAPOLIS, IN 46227

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	250 give 2 units and if 251 to 300 give 4 units of insulin. The Blood Glucose Sliding Scale Coverage Flowsheet, dated 2/11/11 at 6:00 a.m., indicated the resident's blood glucose result was 240 and there was no documentation to indicated the resident had received any insulin and should had received 2 units. On 2/18/12 at 4:00 p.m., the resident's blood glucose result was 284 and indicated the resident had received 2 units instead of 4 units of insulin. On 2/26/12 at 4:00 p.m., the blood glucose result was 229 and had received 4 units instead of 2 units of insulin. On 3/3/12 at 6:00 a.m., the blood glucose result was 200 and there was no documentation to indicate the resident had received any insulin and the resident should had received 2 units. On 3/7/12 at 10:30 a.m., the Director of Nursing Services (DNS) was interviewed in regard to Resident C's incorrect insulin dosages with a sliding scale. The DNS indicated she had problems with the night shift obtaining the blood glucose results early at 6:00 a.m., instead of closer to 7:00 a.m., and breakfast was not served until 7:30 a.m. The DNS further indicated she had reviewed Resident C's Nurses Notes and did not find any documentation in regard to the blood glucose testing and incorrect insulin dosage. This federal tag is related to Complaint # IN00103620. 3.1-25(a)		glucose results and insulin administration.III. The facility has reviewed the procedure for documenting blood glucose results and insulin administration. Sliding scale orders will now be placed in front of theblood glucose log records in the medical record for easier access for documentation by the licensed staff. This change will facilitate improved documentation. Licensed nurses have been educated on this change. IV. The Director of Nursing or her designee is conducting quality improvement audits of the resident's blood glucose log records and insulin administration. A random sample of 5 record audits of residents receiving insulin therapy will continue weekly for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary.	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure the nurses documented consistently the administration of insulin administration. This deficiency affected 1 of 3 diabetic residents who received insulin in a sample of 3 (Resident B). Findings include: The closed clinical record of Resident B was reviewed on 3/7/12 at 9:30 a.m., and indicated Resident B's diagnoses included, but were not limited to, diabetes. The Physician's Order, dated 11/8/11, indicated an order to increase Lantus insulin from 10 units to 14 units subcutaneously daily	F0514	**F514 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ ACCESSIBLE** It is the practice of Madison Health Care Center to maintain each resident's clinical record in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. I. Resident B no longer resides in the facility. II. Residents who receive insulin have the potential to be affected. III. The facility has reviewed the procedure for documenting insulin administration. License nurses have been re-education reinforcing the importance of documenting medication	04/01/2012

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	The Medication Administration Record (MAR) indicated give the resident Lantus 10 units of insulin at bedtime. There was no documentation on 11/7 and 11/8/11 the resident had received the 10 units of insulin. There was no documentation the resident had received 14 units as ordered on 11/8 on the dates of 11/8, 11/9, 11/10, 11/12 and 11/13/11. There was documentation on the MAR the resident had received 10 units of Lantus on 11/10/11. On 3/7/12 at 1:15 p.m., the Director of Nursing Services (DNS) was interviewed in regard to the lack of documentation of Lantus insulin of Resident B's November MAR. The DNS indicated she did not know why the nurses had not signed out the insulin as given and indicated if the nurses were not giving the insulin the resident's blood sugars would had been higher than they were. This federal tag is related to Complaint #IN00103620 3.1-50(a)(1)		administration when performed. IV. The Director of Nursing or her designee is conducting quality improvement audits of the resident's medication administration record. A random sample of 5 record audits of residents receiving insulin therapy will continue weekly for 30 days; then monthly for 6 months. Results of all audits are reported to the facility's quality assurance committee monthly for additional recommendations as necessary.	